

A Brief History of the Prevention and Public Health Fund: Implications for Public Health Advocates

The nation's first broad-based, mandatory investment in public health and prevention, the Prevention and Public Health Fund (the Fund), has had a brief and controversial history.

Advocates for the Fund have had to defend it from both Democratic and Republican threats, including being used as an offset for administration priorities, and from congressional efforts to repeal and replace the Patient Protection and Affordable Care Act.

Lessons learned from efforts to sustain the Fund are instructive in addressing current and future challenges faced by advocates for public health programs and prevention policies. (*Am J Public Health*. 2019; 109:572–577. doi:10.2105/AJPH.2018.304926)

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See also Auerbach, p. 533.

The Prevention and Public Health Fund (the Fund), enacted as part of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, is the nation's first broad-based, mandatory source of federal funding for public health programs. Intended to “provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public health care costs,” the Fund was initially authorized at \$18.75 billion between fiscal year (FY) 2010 and FY2022 and then \$2 billion annually.¹

Public health advocates had long sought such a guaranteed investment in preventive health services, including a “wellness trust” proposed by then-Senator Hillary Clinton (D-NY), given that the United States has some of the poorest health outcomes and spends the most on health care delivery among peer countries globally.^{2–4} Lessons learned from efforts to advocate for and sustain the Fund in a policy environment of extreme partisanship and unyielding attempts to repeal the ACA are instructive in addressing current and future challenges faced by advocates for public health programs and prevention policies.

The Fund's statute is broad and authorizes use of funds for a number of activities and grant programs:

The Secretary shall transfer amounts in the Fund to accounts

within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act [42 U.S.C. 201 et seq.], for prevention, wellness, and public health activities including prevention research, health screenings, and initiatives, such as the Community Transformation grant program, the Education and Outreach Campaign Regarding Preventive Benefits, and immunization programs.⁵

The Fund's intentional mandatory design was meant to ensure consistent, predictable, and expanded resources for prevention and public health that are not always politically viable in the annual appropriations process, wherein public health and prevention programs compete against other priorities in the funding process. However, history shows that this promise was never fully realized. Fund investments have been used by Congress since FY2014 to supplant rather than supplement a variety of programs administered by the Centers for Disease Control and Prevention (CDC) and other agencies of the Department of

Health and Human Services (DHHS), including several initiated with funding from the American Recovery and Reinvestment Act of 2009 and then sustained by the Fund after time-limited “stimulus” funds had expired (Table 1).

The death of Senator Ted Kennedy (D-MA) in August 2009, just months before the final vote on the ACA, meant that the Democrats' 60-member supermajority needed to guarantee its passage was at risk, and eventually it was lost when the seat flipped Republican. To quickly advance the bill, there was no conference committee established to combine the Senate and House versions. Instead, the Senate version of the ACA was approved and then quickly passed by the House by a 219 to 212 vote on March 21, 2010; it became law upon President Obama's signature on March 23, 2010.

It is important to note that the Senate version of the ACA became law despite a much higher initial Fund investment proposed by the House (\$4.6 billion vs \$500 million in the Senate), in addition to larger annual increases

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TABLE 1—Prevention and Public Health Fund Transfers by Department of Health and Human Services (DHHS) Agency Budget Authority (in \$ Millions), by Fiscal Year (FY): United States

Agency	2010 Actual	2011 Actual	2012 Actual	2013 Actual	2014 Actual	2015 Actual	2016 Actual	2017 Actual	Agency Total, 2010–2017	Agency % of Total, 2010–2017	FY2018 President's Budget
ACL	0	0	20	9	28	28	28	28	141	1.9	0
AHRQ	6	12	12	7	7	0	0	0	44	0.6	0
CDC	192	611	809	463	831	886	892	891	5575	76.9	841
CMS	0	0	0	454 ^a	0	0	0	0	454 ^a	6.3	0
HRSA	271	20	37	2	0	0	0	0	330	4.6	0
OS	12	19	30	0	0	0	0	0	61	0.8	0
SAMHSA	20	88	92	15	62	12	12	12	313	4.3	0
Total after sequestration	500	750	1000	949	928	927	932	931	6918	95.4	841
Sequestered			51	72	73		68	69	333	4.6	59
Total	500	750	1000	1000	1000	1000	1000	1000	7250	100	900

Note. ACL = Administration for Community Living; AHRQ = Agency for Healthcare Research and Quality; CDC = Centers for Disease Control and Prevention; CMS = Centers for Medicare & Medicaid Services; HRSA = Health Resources and Services Administration; OS = Office of the DHHS Secretary; SAMHSA = Substance Abuse and Mental Health Services Administration. Individual amounts may not sum to totals owing to rounding.

Source. Lister.¹ Prepared by the Congressional Research Service based on HHS agency congressional budget justifications for fiscal year (FY) 2012 through FY2018.

^aFunds were used for implementation of insurance exchanges under the Patient Protection and Affordable Care Act.

(Table 2).⁶ Also, the House version included more prescriptive language to keep Congress from using the Fund for purposes not specifically stated in the bill, and this language was not incorporated into the Senate version.⁶ The need for this language would become a significant issue in future years as the Fund was used by Congress to offset sequester funding cuts

and used by both the Obama and Trump administrations to support presidential priorities rather than core public health programs.

A BRIEF HISTORY OF THE FUND

In the first year of its implementation (FY2010), the House

and Senate appropriations committees did not allocate the Fund because the FY2010 appropriations bills were passed before the passage of the ACA in March 2010. This gave then–DHHS Secretary Kathleen Sebelius the opportunity to use the Fund to support Obama administration priorities. Specifically, Sebelius transferred \$250 million of the Fund's FY2010 allocation (\$500 million) to strengthen the primary care workforce, including \$168 million for primary care residency program expansion, a move that many believed was not true to the Fund's stated intent to support “prevention, wellness, and public health activities including prevention research, health screenings.”⁵ The Obama administration's decision to use the Fund for its priorities in FY2010 would portend future uses of the Fund to support activities that broadly met the intent of the statute but were seen by many as not fully meeting the letter of the law.

The enactment of the Budget Control Act in August 2011 affected overall federal funding, including the Fund's future growth. In an effort to address the federal deficit, Congress created the bipartisan Joint Select Committee on Deficit Reduction, which was charged with creating a plan to slow government spending. The committee was given a specific deadline and an ultimatum: unless a deal was negotiated, automatic spending cuts (sequester) would be triggered starting in FY2014. The committee's eventual failure to negotiate a bipartisan budget deal did result in major funding reductions across the federal government, including Fund investments in prevention and public health, beginning in FY2014.

In February 2012, Congress passed and President Obama signed legislation to cut the Fund by \$6.25 billion over 9 years (FY2013 to FY2021) to correct the Medicare sustainable growth

TABLE 2—Comparison of Proposed Senate Public Health and Prevention Fund and House Public Health Investment Fund Appropriations: United States

Year	Senate Patient Protection and Affordable Care Act (Prevention and Public Health Fund), \$	House Affordable Healthcare for America Act (Public Health Investment Fund), \$
2011	750 000 000	4 600 000 000
2012	1 000 000 000	5 600 000 000
2013	1 250 000 000	6 900 000 000
2014	1 500 000 000	7 800 000 000
2015	2 000 000 000	9 000 000 000
2016–present	2 000 000 000	... ^a

Source. Cornerstone Government Affairs.⁶

^aNone stated.

rate and prevent cuts to physician services in the Medicare program (known as the “doc fix”).^{7,8} Although opposition to the Fund’s use for the “doc fix” was raised by pro-Fund advocates, the administration’s decision prevailed. Representative Henry Waxman (D-CA), a public health champion, argued against the use of the Fund for the sustainable growth rate correction, stating that “it is certainly not right to reduce our commitment to prevention by robbing the prevention fund of critical dollars that could help keep people healthy instead of paying for them when they are sick.”⁸

The following year, congressional Republicans refused to appropriate FY2013 funds for ACA enrollment activities. In response, the Obama administration used almost half of the Fund (\$454 million of \$949 million) to support ACA outreach and enrollment activities at the Centers for Medicare & Medicaid Services (CMS). Although supporters of the Fund understood the need for individuals to enroll in health insurance, Senator Tom Harkin (D-IA), an architect of the Fund and a key champion, chided the administration’s move and questioned President Obama’s commitment to prevention and public health because of it.⁹

Soon after these moves, critics began to question investments in community-based prevention and local public health programs supported by the Fund, including the Community Transformation Grants (CTGs) administered by the CDC.¹⁰ Ironically, the Obama administration’s “open government initiative” and the president’s commitment to transparency may have been a factor in catalyzing anti-Fund advocacy.¹¹ The Obama administration’s transparency

efforts allowed opponents to easily review CTG and other grantee reports describing funded activities. These reviews led Fund critics to raise what they viewed as controversial uses of federal dollars with their members of Congress despite the Fund’s stated intent to support evidence-based, population-wide community programs at the local level as a means of promoting health and preventing disease, with CTGs specifically named in the authorizing statute.⁵

The politicization of the CTGs was driven by conservative views that public health activities represented governmental intrusion into the private lives of Americans and that Fund programs at the local level were bad for business.¹² Several members of Congress accused the CDC and its grantees of misappropriation of federal funds to lobby elected officials to increase tobacco taxes and fees, advocate for sugar-sweetened beverage taxes or fees, and lobby for increasing the required distance of fast-food restaurants from schools.^{13,14} Grants to promote physical activity and nutrition (including exercise classes, purchase of recreational equipment for parks, purchase of retail coolers to store fresh fruit and vegetables in food desert neighborhood convenience stores, and projects to complete sidewalks) were seen as additional examples of governmental oversteps and broadcast widely in media stories critical of the Fund.

Subsequent reviews did not show any misappropriation of federal dollars and demonstrated that all but one of the programs in question were legacy Communities Putting Prevention to Work programs funded by the American Recovery and Reinvestment Act and not by the

Fund (CDC, unpublished data, 2012).¹ Furthermore, no documented examples of inappropriate lobbying were discovered, and the DHHS issued new grantee guidance to clarify allowable uses of federal funds. However, questions concerning the Fund’s use ultimately led to the early termination of the CTG program.

As late as the summer of 2017, 4 years after the CTG program had ended, many in Congress still referred to the Fund’s use in promoting what they deemed to be questionable public health programs, harking back to criticisms of the Fund as a “slush fund” and despite Congress’ clear transfer authority in the Fund’s statute.^{9,12,15} Despite the suspension of the CTGs, the Fund continues to sustain several innovative public health programs developed early in its implementation, such as the Diabetes Prevention Program and other significant federal initiatives including efforts to improve reporting and prevention of health care–associated infections.

As noted, the Joint Select Committee on Deficit Reduction’s failure to develop a bipartisan plan to slow government spending meant that sequester cuts were implemented in FY2014 and were to last through FY2021. These cuts applied to discretionary funding but also nonexempt, mandatory funding, including the Fund. To address FY2014 shortfalls, DHHS leaders and congressional appropriators supplanted the CDC’s core budget authority with almost \$900 million from the Fund.

Given the decrease in dollars available owing to automatic cuts and other significant changes to the budgeting landscape that were the result of the Budget Control Act, the use of the Fund

for these programs was seen as a positive move in that they may have been significantly reduced or eliminated outright without the Fund to support them. A consequence of moving CDC program funding from CDC’s budget authority to the Fund, however, is that many important CDC programs (e.g., immunization, tobacco prevention) are now subject to elimination or significant reductions in proposals to repeal the ACA. It also meant that funds intended for new investments in prevention and public health were supplanted by existing programs needing funds to continue.

After the election of Donald Trump as president in 2016, Republicans controlled the House, the Senate, and the White House, and the party’s push to eliminate the ACA became very real. Congress approved a budget resolution instructing the committees of jurisdiction to identify programs to cut through the budget reconciliation process. Republican leadership in Congress had set repeal of the ACA as a legislative priority for the new majority, with more than 50 repeal attempts by the House of Representatives between 2011 and 2014 and 70 attempts in 2017.^{16,17} Efforts to repeal the ACA were brought to a head in 2017, when a “skinny repeal” bill to eliminate the ACA was blocked by just 3 Republican senators voting no.¹⁸ Should any one of these ACA repeal efforts have been passed and signed by the president, the Fund would have been eliminated.

In 2017 and early 2018, public health advocates rallied to save the Fund, and for the first time national media coverage of efforts to repeal and replace the ACA included significant mentions of the Fund and the consequences

of its repeal for the ability of governmental agencies to protect the public's health.^{19–21} Despite the continued need to use the Fund to support core CDC programs in late 2017 and early 2018, the CHAMPIONING HEALTHY KIDS Act employed the Fund to extend the Children's Health Insurance Program and community health center programs; this was reminiscent of prior uses of the Fund to pay for important federal programs not viewed generally as population-based public health or prevention activities. A familiar “robbing Peter to pay Paul” dynamic ensued, with Congress approving the use of \$100 million from the Fund in FY2019 to pay for health care delivery provided by the Children's Health Insurance Program and community health center programs.

The Bipartisan Budget Act, passed by Congress on February 7, 2018, restored the Fund but included a \$1.65 billion cut in FY2022 and beyond (Table 3). Advocates' desire to keep the Fund whole at current levels in the near term outweighed their opposition to out-year cuts. As

passed, the Bipartisan Budget Act decreases the Fund's appropriations on an annual basis after FY2022 and then provides \$2 billion in FY2028 and each fiscal year thereafter. Another provision of this legislation was an increase in sequester caps for both nondefense discretionary and defense discretionary funding for FY2018 and FY2019, which enabled the appropriations committees to provide additional resources to important public health and other programs.

The Consolidated Appropriations Act of 2018, signed by President Trump on March 23, 2018, included increased appropriations for several CDC programs. With the raised discretionary caps, \$350 million in new funding for public health responses to the opioid crisis was added to the CDC's overall FY2018 budget, and the Fund was left intact. This legislation represented the largest single increase to the CDC's budget in the last 10 years, ending months of worry that the Fund would be cut entirely and that governmental public health agencies would

have to cut staff and end critical programs and services.

IMPLICATIONS FOR PUBLIC HEALTH ADVOCACY

The controversial history of the Fund is no surprise to veteran public health advocates who have spent years arguing for prevention as a way to improve the health of all Americans and to reduce the rising cost of health care. Unfortunately, the folk adages of “an ounce of prevention is worth a pound of cure” and cuts to prevention are “pennywise and pound foolish” often fall on deaf ears in Congress, where louder and more powerful interests in health care delivery, treatment, biomedical research, pharmaceuticals and clinical care prevail.

However, the history of the Fund should inspire, not dishearten, public health advocates. Successful advocacy over the past 9 years has been effective in highlighting the importance of federal investments in prevention

and public health and understanding opposition to them. Key tactics in effective Fund advocacy have included emphasizing the nonpartisan nature of prevention and improving the public's health, cultivating Fund champions in Congress, and tying Fund investments to broader national conversations about controlling health care costs by moving from a focus on health care “volume” and fee for service toward health care “value” and incentivizing prevention and wellness through bundled payments and other new payment models.

Nonpartisan Nature

The Fund's authorization within the ACA made a tremendous amount of sense given the ACA's intent to both expand access to health care and reduce health care costs by covering clinical preventive services and investing in public health. The Fund's association with the ACA, however, has also made it a target in Republican attempts to repeal and replace the ACA. Efforts to generate bipartisan support for

TABLE 3—Future Prevention and Public Health Fund (PPHF) Appropriations in the Bipartisan Budget Act: United States, 2018–2028

Fiscal Year	Previous PPHF Funding Levels (Prior to 12/2017), \$ Millions	Current Law PPHF Funding Levels (Approved 12/2017), \$ Millions	Bipartisan Budget Act of 2018, \$ Millions	Change From Previous PPHF Levels to Bipartisan Budget Act, \$ Millions	Change From Current Law to Bipartisan Budget Act, \$ Millions
2018	900	900	900	0	0
2019	900	800	900	0	100
2020	1000	800	950	0	150
2021	1000	800	950	0	150
2022	1500	1250	1000	–400	–250
2023	1000	1000	1000	0	0
2024	1700	1700	1300	–400	–400
2025	2000	2000	1300	–400	–400
2026	2000	2000	1800	–200	–200
2027	2000	2000	1800	–200	–200
2028	2000	2000	2000	0	0

Source. Consolidated Appropriations Act of 2018 (Public Law No. 115-141).

the Fund have been met with stiff resistance from many Republicans with long-standing negative views about the role of government in improving the public's health as well as from Republicans who oppose the Fund's mandatory nature. There are Republicans who are supportive of the intent of the Fund, but their support is largely shared "behind the scenes" lest they be viewed as breaking ranks from the party's call to repeal and replace the ACA.

Whether visible or behind closed doors, effective advocacy for the Fund is based on understanding differences in the health policy perspectives of Democratic and Republican legislators. A study of differences between state legislators' perspectives on health showed that Republican lawmakers prioritized cost reduction and smaller government over 11 other health policy goals such as increasing access to health insurance and reducing health disparities.²² The same study revealed that Democratic lawmakers prioritized improving overall health, increasing access to health care, and reducing health disparities, and Democratic lawmakers did not prioritize cost reduction or smaller government in the same way as Republicans. When applied to members of Congress, these findings help explain continued Democratic support for the ACA and Republican efforts to repeal it but also provide insight on how to engage in public health and prevention advocacy with Republican lawmakers.

Recent advocacy for the Fund includes addressing Republican priorities such as how prevention helps contain health care costs and how public health programs promote an appropriate balance between individual and community responsibility for health outcomes. These messages have resonated with some Republican

members of Congress. Overall, Republican opposition to the Fund has been based on its association with the ACA writ large and concerns about its mandatory versus discretionary nature, not the virtue of prevention. This technical aspect of the Fund has been addressed with clear advocacy messages about sustaining public health and prevention funding regardless of the mechanism and the fact that most of the CDC programs supported by the Fund have had long-standing, bipartisan support, with some programs dating back as early as the 1980s.

In addition to highlighting the impact of the Fund's investment in health, advocates should continue to tie their messages about the Fund to core Republican beliefs such as the importance of states' rights and individual autonomy and agency.^{23,24} Advocates for the Fund should also continue to stress how Fund programs ensure a productive and healthy America and promote the nation's health security, and they should emphasize how most state and territorial health departments have discretion over the direction and implementation of Fund programs to meet their specific needs. Of course, Fund advocates should continue to promote the nonpartisan and aspirational goal of every American's ability to achieve optimal health and how the Fund contributes to meeting that goal through the programmatic work it supports at the federal, state, and local levels.

Developing Champions in Congress

A key strategy used by any seasoned advocate is to build congressional champions for a cause. Although the Fund's early champions have retired, advocates have recently worked to cultivate new champions vital to defending

the Fund such as Senator Patty Murray (D-WA). Congressional appropriators on both sides of the aisle are important Fund champions given that their jobs will be extremely difficult if the Fund is eliminated and funding for core public health programs, including immunizations, tobacco control, and the Preventive Health and Health Services Block Grant, will have to be found elsewhere if these programs are to be sustained. This makes it essential that future advocacy for the Fund clearly demonstrates the nonpartisan nature of Fund investments in core public health programs and the budgetary and political pressures that potential Fund elimination or reduction will create for appropriators.

Developing champions is no small feat with 535 members of Congress, many of whom have little direct knowledge of the Fund and its impact. This makes it essential for Fund advocates to educate and inform members of Congress about the importance of the Fund, even if advocates are employed by governmental public health agencies and their ability to lobby is limited by their positions as civil servants and staff members of executive branch agencies. Although government employment does not prohibit individuals from exercising their Constitutional right to advocate, it does complicate such efforts. Governmental public health employees in particular stand to lose a great deal if the Fund is eliminated: 12% of the CDC's overall budget came from the Fund in FY2017, and thousands of jobs at the federal, state, and local levels would be lost if the Fund were to be cut. Increased advocacy from governmental public health leaders is needed to educate policymakers on the impact of cuts to the Fund on the public's health and to make the case for continued support.

Public health advocacy has generally focused on funding for categorical programs rather than for cross-cutting "top-line" appropriations, including an array of advocates lobbying for specific public health programs in the Fund such as epidemiology and laboratory capacity, the Preventive Health and Health Services Block Grant, and immunization capacity building. In a move away from this stovepipe approach, the Association of State and Territorial Health Officials, along with more than 70 other national public health associations and interest groups, launched a campaign to increase overall CDC funding for public health and prevention. The "22 by 22" initiative, modeled after advocacy efforts in the late 1990s and early 2000s to double the budget of the National Institutes of Health, aims to increase the CDC's budget by 22% by the year 2022. Champions of this initiative could demonstrate support overall for public health investments at the CDC without specifically mentioning the Fund, a move that might allow some members of Congress to support the CDC's work without being perceived as supporting the ACA.

Tying Fund Advocacy to Efforts to Lower Costs

Rising health care costs are top of mind for both Democratic and Republican lawmakers as more and more of the federal budget is used to fund Medicare, Medicaid, and other health care programs and more constituents voice concerns about the costs of health care for their businesses or their families. Fund advocates can specifically address the role of Fund investments in bending the health care cost curve and demonstrate the value of prevention

